

**Neurasthenia: Science and Society in the American Victorian Era**  
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*Neurasthenia was used by nineteenth-century American doctors to explain a wide variety of symptoms not satisfactorily covered by existing diseases. It was not a discrete illness, but rather a disease category that attributed a variety of ailments to the nervous system, and proved to be flexible in its scientific applications. This study briefly explains the origins of neurasthenia in the United States before taking an in-depth look at the various methods used to treat nervous disease in the late nineteenth century. Special attention is given to explaining Victorian-era electrical therapy using rare and previously unexamined sources found at the Bakken Museum and Library in Minneapolis, Minnesota, USA. It also examines neurasthenia in women, focusing on the patients of Dr. S. Weir Mitchell, creator of the rest cure, and the life and practice of Dr. Margaret Cleaves, a prominent female physician who ran the New York Electro-Therapeutic Clinic and Laboratory.*

## Introduction

As the prolific field of the history of medicine and science has demonstrated, medicine is a reflection of culture and contains a social history as much as any aspect of civilization. The framing and treatment of mental illness in particular lays bare a society's ideological framework. As described by Dr. George Miller Beard, the man who coined the disease, neurasthenia was 'a *condition* of the system that is, perhaps in our time at least, the cause and effect of disease.'<sup>1</sup> Neurasthenia was not a discrete illness, but rather a disease category that attempted to unify and explain a wide variety of symptoms not satisfactorily covered by previously defined diseases. Much is misunderstood about neurasthenia, and, drawing on a variety of original texts, this article attempts to provide a clear account of the development of the disease category, and elucidate the social and scientific context within which it emerged and faded over the course of the latter nineteenth and early twentieth centuries in the United States. In particular, it seeks to develop an understanding of the use and importance of electricity in the treatment of neurasthenia using the works of Dr. Alphonso David Rockwell, the largely forgotten professional partner of George Miller Beard, and materials from the New York Electro-Therapeutic Clinic. The article then transitions to an analysis of the role of women in the development of neurasthenia, first addressing the gendered construction of the rest cure, a treatment that developed after women began to be diagnosed with neurasthenia that was rarely applied to men. Drawing on recent scholarship, it proposes a more nuanced understanding of the controversial figure of Dr. Silas Weir Mitchell, creator of the rest cure made famous by his negative encounter with the author Charlotte Perkins Gilman. The final section analyzes Dr. Margaret Cleaves' *Autobiography of a Neurasthene*.

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<sup>1</sup> George M. Beard, 'Neurasthenia, or Nervous Exhaustion,' (1869) *The Boston Medical and Surgical Journal*, 3(13), p. 217. Beard's emphasis.

Although previous studies of neurasthenia refer to Cleaves and her work in passing, this article provides the first detailed examination of her medical memoirs.

Beard and other nineteenth-century neurologists believed that individuals were born with a fixed amount of 'nerve force,' a hypothesized source of energy that travelled through the nervous system. As individuals and races became increasingly refined, their innate stores of nerve force simultaneously shrank. Beard attempted to illustrate his point by likening neurasthenia to anemia: '*Anaemia* is to the vascular system what *neurasthenia* is to the nervous. The one means want of *blood*; the other, want of *nervous force*.' Beard argues ailments 'are part of the compensation for our progress and refinement.'<sup>2</sup> Beard acknowledged his thesis' main weakness, stating, 'In regard to the pathology of neurasthenia we are compelled, in the absence of definite knowledge, to reason from logical probability,'<sup>3</sup> and provided pages of symptoms with which to recognize neurasthenia, including 'flushing,... bad dreams, cerebral irritation, dilated pupils,... fear of everything,... hopelessness,... general or local itching [etc].'<sup>4</sup> Neurasthenia did not imply an 'unbalanced mental organization' or 'a relative inferiority of intellectual nature.'<sup>5</sup> A neurasthenic simply 'has a narrow margin of nerve-force.'<sup>6</sup> Neurasthenia was a physical condition, and, most importantly, was not the fault of the neurasthenic. It quickly became a mark of status because it implied that the sufferer was a member of the American professional class.<sup>7</sup> Lower classes in American society were initially not believed to be susceptible to neurasthenia. As Dr. I.N. Love, vice-president of the American Medical Association, explained:

I still urge with Beard that it [neurasthenia] is seldom found among those who live below the upper crust of the social world. ... The manual laborers of the world, however little they may know, generally know enough to rest when they are tired, and they have the advantages of fewer superheated and poorly ventilated homes, besides their muscular development holds down their emotional centers to a safe level.<sup>8</sup>

The first doctors to adopt the diagnosis of neurasthenia were neurologists, a small group of specialists who studied the nervous system. The field bore no resemblance to modern neurology, and in 1870, was far removed from modern and contemporary psychiatry.<sup>9</sup>

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<sup>2</sup> Ibid., p. 217.

Modern readers studying neurasthenia will draw an immediate parallel to depression and other mental illnesses whose biological and pathological underpinnings are contested, and which are diagnosed symptomatically. Like neurasthenia, depression is characterized as a chemical imbalance, i.e. a physical ailment, and therefore treatable and the focus of 'legitimate' medicine. In the language of nineteenth-century medicine, nervous illness was defined as a physical disease distinct from categories of mental illness, i.e. madness, which were seen as hopeless cases and therefore primarily the responsibility of non-medical, religious and humanitarian personnel and institutions.

<sup>3</sup> Ibid., p. 218.

<sup>4</sup> George Miller Beard, *American Nervousness, Its Causes and Consequences*, G.P. Putnam's Sons, New York, 1881, pp. 7-8.

<sup>5</sup> Beard, 1881, p. 1.

<sup>6</sup> Ibid., p. 9.

<sup>7</sup> In addition to an obvious correlation with the modern disease category of depression, neurasthenia also has a strong relationship to the modern idea of 'stress.' See conclusion and Gosling, p.192.

<sup>8</sup> I.N. Love, 'Neurasthenia,' *Journal of the American Medical Association*, 1894, pp. 22, 540.

<sup>9</sup> F.G. Gosling, *Before Freud: Neurasthenia and the American Medical Community, 1870-1910*, University of Illinois Press, Chicago, 1987, pp. 19-21.

Nineteenth-century American psychiatry was not the highly medicalized field it is today. From the 1830s, the Alienists, so named because they worked with people who were 'alienated' from society (usually in

The members of the American Neurological Association (ANA) were mostly neurologists practicing in urban centers along the East Coast and were the recognized 'leaders in advising on the diagnosis and treatment of neurasthenia.'<sup>10</sup> In his landmark study of all 332 journal articles published on the subject of neurasthenia between 1870 and 1910, F.G. Gosling found that over two-thirds (205) of the 307 individual patient cases reported were from ANA doctors. However, of the 102 remaining cases, non-neurologists reported seventy-four, demonstrating that physicians in other fields had adopted neurasthenia and actively contributed to the literature on the topic. Additionally, the population of patients discussed in those case histories was unexpectedly diverse. Professional-class workers were the largest identifiable group, but over a quarter of the 217 patients whose occupations were identified were skilled or semiskilled workers of the lower-middle class.<sup>11</sup>

Some neurologists resisted the application of the term 'neurasthenia' to these new patients and their ailments. In his preface to the third edition of Beard's *A Practical Treatise on Nervous Exhaustion* (1894), A.D. Rockwell wrote a scathing denunciation of lithemic, also known as 'spinal' neurasthenia, which was widely diagnosed among lower middle-class patients:

The doctrine to be taught and strongly enforced is that many of these patients are not neurasthenic, and under hardly any conceivable circumstances could they become neurasthenic. They do not belong to the type out of which neurasthenia is born, either mentally or physically. Many of them are unintellectual, phlegmatic, and intolerably indolent, and are pleased at a diagnosis which touches the nerves rather than the stomach...<sup>12</sup>

From the patient records of his private electrotherapy practice, it is clear that Rockwell used the diagnosis of neurasthenia sparingly. A majority of those patients who managed to earn a neurasthenia diagnosis came to Rockwell on referral from Dr. St. John Roosa, founder of the Manhattan Eye, Ear, and Throat Hospital, and on the faculty at New York University's Medical College. Nearly all of those patients paid in advance for treatment, and, when their occupations were listed, they were invariably professional fields. Unfortunately, Rockwell rarely wrote down detailed accounts of his neurasthenia cases.<sup>13</sup> Rockwell was a prolific author on the topic of electrical stimulation therapy, of which he and Beard were the reigning authorities. As a result, electrotherapy became one of the first and most popular treatments of neurasthenia. It has become, however,

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asylums), were recognized primarily as 'mental therapists.' They believed that 'simple humane care and "moral" treatment could cure mental illness and educate the insane to mental health.' Gosling, 19.

<sup>10</sup> Ibid., p. 31.

<sup>11</sup> Ibid., pp. 31-32.

<sup>12</sup> George Miller Beard, *A Practical Treatise on Nervous Exhaustion, Neurasthenia: Its Symptoms, Nature, Sequences, Treatment*, A.D. Rockwell, ed., E. B. Treat, Third Ed., New York, 1894, p. 3. Legacy Reprint by Kessinger Publishing

Lithemic neurasthenia was very similar to earlier constructions of nervous illness, such as 'the English Malady' defined by the eighteenth-century Scottish physician George Cheyne, which were associated with indulgence, particularly in food, rather than with overwork. See: George Cheyne, *The English Malady; or, A Treatise of Nervous Diseases* (1733) and Roy Porter, 'Nervousness, Eighteenth Century Style: From Luxury to Labour,' *Cultures of Neurasthenia: From Beard to the First World War*, Marijke Gijswijt-Hofstra and Roy Porter, eds, Editions Rodopi B.V., New York, 2001.

<sup>13</sup> Alphonso David Rockwell, Unpublished Notebook, circa 1862 to 1874. Bakken Museum and Library, Minneapolis, Minnesota, USA.

Despite his rejection of lithemic neurasthenia, Rockwell co-authored with Beard an entire volume on the nature of sexual neurasthenia, a subcategory which was most common among working-class and young men.

one of the least examined and most misunderstood treatments, especially compared to S. Weir Mitchell's rest cure.

### Treating Neurasthenia: Electricity and the Rest Cure

In the 1870s, the three most frequently recommended treatments for neurasthenia were (in preferential order) drugs, rest, and electrotherapy. Neurasthenics belonging to the professional class most frequently sought treatment from nerve specialists, while the growing population of working-class and rural neurasthenics relied on dispensaries and charity clinics for relief. For the latter group, drugs were often their only form of treatment, although electrical stimulation therapy was sometimes available through clinics and teaching hospitals, as discussed below.<sup>14</sup>

It is important to differentiate between electrical stimulation therapy and electroshock therapy. Electroshock therapy is a post-World War II creation that involves the passing of strong electric currents through the body, often to the point where the patient is catatonic, in order to cure depression. Electrical stimulation therapy was a Victorian practice more akin to the modern TENS muscle stimulators.<sup>15</sup> Although sometimes painful depending on where the electricity was applied, electrical stimulation therapy used much weaker currents than electroshock therapy, and was widely popular in the United States and Europe. George Miller Beard and A.D. Rockwell were 'electricians,' and wrote the cornerstone text on the subject, *A Practical Treatise on the Medical and Surgical Uses of Electricity: Including Localized and Central Galvanization, Franklinization, Electrolysis and Galvano-Cautery* (1871).

According to A.D. Rockwell, earlier scientists believed that electrical stimulation therapy was an effective curative therapy because electricity was 'identical to nerve force, or, at least, that it was directly transformed into it.' Beard seems to have believed in some sort of direct exchange, writing that the application of electric currents 'directly improve[d] the quantity and quality of the vital force.'<sup>16</sup> However, Rockwell, saw 'no evidence that electricity is identical with life.' 'Like light and heat it may sustain life... through its influence over nutrition.'<sup>17</sup> Electricity was classified as a 'stimulating sedative tonic' because, after its initial stimulating effect on the body's systems, it reduced pain and 'induced natural repose,' and, like a tonic, 'gradually improved nutrition, restored enfeebled functions, invigorated the system, and permanently increase[d] its capacity for labor.'<sup>18</sup>

There were several forms of electrical stimulation therapy. General, as in 'general franklinization,' implies electrical stimulation of the entire body. Central, as in 'central galvanization,' refers to the stimulation of the central nervous system, while local, as in 'local faradization,' involved only targeted areas of the body. Methods of application were also classified according to the current they used. The faradic current was not believed to be able to penetrate the central nervous system and directly affect the brain and spinal cord, although it was widely used to stimulate the sympathetic nervous

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<sup>14</sup> Gosling, p. 118.

<sup>15</sup> Dr. Gail Hornsetin, lecture on 23. September 2010. Professor Mary Renda, discussion on 15. April 2011. I had the opportunity to try out one such machine at the Bakken Museum in Minneapolis, Minnesota, and found it to be a surprisingly pleasant experience.

<sup>16</sup> Beard, 1869, p. 219.

<sup>17</sup> A.D. Rockwell, *The Medical and Surgical Uses of Electricity: Including the X-Ray, Finsen Light, Vibratory Therapeutics, and High-Frequency Currents.*, E.B. Treat & Company, New York, 1903, Bakken Museum and Library, Minneapolis, Minnesota. pp. 201-202.

<sup>18</sup> Rockwell, 1903, p. 198.

system.<sup>19</sup> Due to the poor conductive properties of skin, and the relative weakness of the faradic current, either the skin or electrodes were moistened before the electrodes were placed on the targeted areas during localized faradization.<sup>20</sup> General faradization involved bringing ‘the external portions of the body from the head to the feet, and, as far as possible, the internal tissues and organs also, under the influence of the current.’<sup>21</sup> To increase the surface area of the patient’s body exposed to the electricity, the feet of the patient were placed upon a copper plate (the negative pole). In place of an electrode, physicians often used their hands as the positive poles, and stroked the patient’s wet hair, face, back, and limbs until treatment was complete.<sup>22</sup> In his original 1869 article, Beard described general faradization as his preferred method of treatment. He emphasized the importance of treating the entire body of the neurasthenic, and discouraged focusing purely on individual locations, writing that ‘to devote the whole attention to special and local phases... is unphilosophical and can never be successful.’<sup>23</sup>

Although general faradization was ‘absolutely indispensable in the practice of electro-therapeutics,’<sup>24</sup> Rockwell preferred the more powerful galvanic current. This was the current most commonly used in the treatment of neurasthenia and nervous illness because, unlike the faradic current, the galvanic current was able to directly affect the functioning of the brain and spinal cord.<sup>25</sup> Local galvanization was a much more delicate procedure than local faradization, and more likely to cause pain if not applied properly. In local galvanization, two electrodes, a negative and a positive end, were either fixed on specific locations on the body (the *stabile* application) or one or both electrodes were gently ‘glided’ over the surface of the skin (the *labile* application). During a *labile* application, pressure and contact remained constant and steady to avoid interrupting the current.<sup>26</sup> Local galvanization was seen to increase the size and strength of poorly nourished and atrophied muscles, and to ‘develop and to increase functional activity’ of organs, such as the uterus.<sup>27</sup>

Because the galvanic current was so powerful, it was rarely used in general applications of electricity. Instead, electricians practiced central galvanization, which brought ‘the whole central nervous system—brain, sympathetic nerves, and spinal cord— under the influence of the galvanic current.’ Central galvanization involved the *stabile* application of one electrode, usually the negative pole, at the solar plexus in the center of the body. The other electrode would be carefully, but firmly, pressed along the top of the head and down the length of the spine. The patient’s hair and skin would be dry during this procedure.<sup>28</sup>

As mentioned above, Rockwell was a conservative physician, and was invested in the perception not only of neurasthenia as an ailment of the elite, but also of the field of medicine as a highly technical, elite profession. His justification for focusing on ‘Methods of Application’ in his fourth *Lecture on Electricity* was that the increase in

<sup>19</sup> A.D. Rockwell, ‘On the Application of Electricity to the Central Nervous System,’ (187-) reprinted from the *New York Medical Journal*, Bakken Museum and Library, Minneapolis, Minnesota, p. 3.

<sup>20</sup> A.D. Rockwell, *Lectures on Electricity in its Relations to Medicine and Surgery*, William Wood & Company, New York, 1881, Bakken Museum and Library, Minneapolis, Minnesota, p. 32.

<sup>21</sup> *Ibid.*, p. 35.

<sup>22</sup> *Ibid.*, pp. 37-38.

<sup>23</sup> Beard, *A Practical Treatise on Nervous Exhaustion*, 1880, First edition, p.133.

The section on electrical therapies is significantly different, and this statement no longer appears in the third edition edited by Rockwell after Beard’s death, published in 1894. A separate section extols the virtues of localized treatment. This is most likely Rockwell’s influence, if not completely his work.

<sup>24</sup> *Ibid.*, p. 39.

<sup>25</sup> Rockwell, 187-, p. 3.

<sup>26</sup> Rockwell, 1881, p. 33.

<sup>27</sup> *Ibid.*, p. 34.

<sup>28</sup> *Ibid.*, p. 40.

popularity of electrical therapeutics meant that there was a reciprocal loss of 'a clear conception of the principles and methods involved.' Rockwell argued that the amateur user of electricity not only risks injury to himself, but also 'injures the profession by making it appear that the medical use of electricity is a simple and trifling thing, and therefore the peculiar province of ignorance and charlatanism.'<sup>29</sup> It is likely that he preferred galvanization to faradization in part because it was more powerful, and therefore implied that its user had a higher level of skill than a doctor that practiced faradization.

Treatment by A.D. Rockwell could cost \$70 or more, but electrical stimulation therapy was not exclusively reserved for the professional class, who sought treatment from neurologists at their private offices.<sup>30</sup> Dr. Margaret Cleaves' New York Electro-Therapeutic Clinic and Laboratory provided treatment to thousands of patients unable to afford medical treatment:

To those who are unable to pay, services are gladly given. ... There are a large class (*sic*) [however,] who find it impossible to pay for electrical treatment in an office, but may in a teaching clinic receive its benefits by the payment of a sum entirely within their power. ... The class of patients who have become our beneficiaries could in no other way have received skilled electrical treatment.<sup>31</sup>

Treatment at the Electro-Therapeutic Clinic was not equal to the treatment received in a private office. Indeed, many physicians who worked in the clinic, including Cleaves, also maintained lucrative private practices.<sup>32</sup> Unlike those who sought treatment with a private physician, patients receiving care from the free clinic rarely received follow-up care. Based on Cleaves' language, it also appears low-income individuals were regularly turned away from the clinic.

Although not affiliated with any teaching hospital, the clinic welcomed recent graduates and senior medical students for training, and offered certificates to those who spent at least three months at the clinic. Of the 110 students to practice at the clinic, approximately fifteen stayed for three months or longer and three stayed for over a year.<sup>33</sup> The clinic was staffed by male and female doctors, but trained nurses were discouraged from applying for a position, and by 1899, were no longer admitted because Cleaves believed 'their presence is felt to be a drawback to the work, which is for the trained medical student and physician.'<sup>34</sup>

Electrical stimulation therapy was used to treat a wide variety of ailments, so the population of patients at the clinic was a diverse group. In 1897, a clear plurality of the 382 total cases fell under the category of 'neurological,' but only 21 of the 104 patients treated for neurological ailments were diagnosed with some form of neurasthenia. Almost half of those cases were not deemed to be legitimate cases of neurasthenia, but

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<sup>29</sup> Ibid., p. 31.

<sup>30</sup> Rockwell, Unpublished notebook, p. 236.

<sup>31</sup> Margaret A. Cleaves, 'The Record of Two Years (1895-97) in an Exclusively Electro-Therapeutic Clinic.', Published by the clinic, New York City, 1897, Bakken Museum and Library, Minneapolis, Minnesota, p. 11.

Also see: Margaret A. Cleaves, 'The Record of Four Years (1895-1899) in an Exclusively Electro-Therapeutic Clinic.', Published by the clinic, New York City, 1899) Bakken Museum and Library, Minneapolis, Minnesota.

<sup>32</sup> Ben Shephard, *A Ward of Nerves: Soldiers and Psychiatrists in the Twentieth Century*, Harvard University Press, Cambridge, 2000, p. 8.

<sup>33</sup> Cleaves, 1899, pp. 19-20.

<sup>34</sup> Ibid., p. 19.

rather were classified as 'Neurasthenia Symptomata' (to be discussed later).<sup>35</sup> By 1899, neurological ailments had lost their plurality by a slim margin to 'Medical' ailments, but remained steady proportionally, increasing slightly from 27% of all cases to 28%.<sup>36</sup>

A wide variety of electrical treatments were available at the clinic. Franklinic Current, a less common medical current than faradic or galvanic currents and one of the more painful variations of electrical stimulation therapy, accounted for almost a third of all treatments. Cleaves advocated it for the wide range of diseases it could be used to treat, and also 'the ease and facility with which it can be applied,' although cautioned that an unskilled hand could cause a patient great discomfort.<sup>37</sup> Cleaves also celebrated the addition of 'electric baths' to the clinic's repertoire. Like Beard, Cleaves believed that 'the best results can only be secured in a variety of diseases by general [or systemic] treatment,' although she also recognized that localized applications of electricity could be beneficial in certain cases of pathogenic disease.<sup>38</sup>

Neurasthenia patients of all classes and categories were often prescribed drugs to combat their illness.<sup>39</sup> For patients who received treatment from a public clinic or dispensary, drugs were often their only treatment, although medicines usually complemented other therapies.<sup>40</sup> On the inside cover of his notebook, Rockwell had taped a pamphlet from John Wyeth & Brother Pharmaceuticals advertising medicines developed to treat nervous patients.<sup>41</sup> 'Bitter Wine of Iron' was made of 'Sherry Wine, Calisaya Bark, and Citrate of Iron.' It was for cases 'of debility, loss of appetite, and general prostration.' 'Ferrated Cordial Elixir' was 'particularly indicated' for 'the general debility, nervous prostration, and loss of vigor of females and children.' Its manufacturer boasted that it 'rival[ed] in delicate and delicious flavor the most prized of the foreign cordials,' and explained that it served to 'stimulate digestion and invigorate the whole system.' Almost all of the medicines listed contained some sort of iron compound to 'build up the blood.'<sup>42</sup> These medicines promised to restore the user's energy, usually by improving digestion. The medicines from Wyeth & Brother's 'Elegant' line of medicines also often contained vast amounts of alcohol because of its anesthetic power and to make otherwise bitter medicines more palatable to elite patients and to children.<sup>43</sup>

In addition to aiding digestion and 'building blood cells,' drugs were frequently used to induce sleep in neurasthenic patients. Chloroform, called 'Chloral,' was 'greatly used, and greatly over-used' as a sedative.<sup>44</sup> Sleep was essential for a neurasthenic's recovery, although Beard recognized that the over-use of sleep-inducing drugs could result in dependency.<sup>45</sup> Dr. Silas Weir Mitchell developed a treatment regimen nominally centered on the healing power of rest. Mitchell first came up with the idea for

<sup>35</sup> Cleaves, 1897, pp. 7, 10.

<sup>36</sup> 187 of 662 cases vs. 195 of 662 cases. 'Medical' implied 'physical' with a clear physical cause and manifestation of disease. Various forms of arthritis make up the majority of 'Medical' ailments, along with constipation and bronchitis.

Cleaves, 1899, pp. 17-18.

<sup>37</sup> Ibid., p. 22.

<sup>38</sup> Ibid., p. 32.

Beard, *A Practical Treatise on Nervous Exhaustion*, 1880, First edition: 'To devote the whole attention to special and local phases... is unphilosophical and can never be successful.'

<sup>39</sup> Gosling, p. 109.

<sup>40</sup> Ibid., p. 118.

<sup>41</sup> John Wyeth & Brother Pharmaceuticals, Philadelphia, 'Elegant Pharmaceutical Preparations.' In: A.D. Rockwell, Unpublished notebook, Bakken Museum and Library, Minneapolis, Minnesota.

<sup>42</sup> Gosling, p. 117.

<sup>43</sup> John Wyeth & Brother Pharmaceuticals. In: Rockwell, unpublished. Bakken Museum and Library.

<sup>44</sup> Beard, 1894, p. 199.

<sup>45</sup> Ibid., pp. 199-200.

his 'rest cure' during the Civil War, when he served as a physician for the Union Army. Mitchell found that 'complete rest and plentiful diet usually brought these [soldiers] up again and in many instances enabled them to return to the front.'<sup>46</sup> By 1900, rest had displaced drugs as the most commonly recommended treatment for neurasthenia.<sup>47</sup>

Mitchell first used the rest cure in a civilian setting in 1874. A wealthy female patient, called 'Mrs. G., of B—, Maine,' came to him 'completely exhausted by having had children in rapid succession and from having undertaken to do charitable and other work to an extent far beyond her strength.'<sup>48</sup> Mitchell rejected the diagnosis of hysteria given to her by other practitioners, believing her problems to be stemming from 'a general condition of nervous excitability due to the extreme of weakness.'<sup>49</sup> Through trial and error with 'Mrs. G,' Mitchell developed a treatment regimen, which he described in his 1877 medical text, *Fat and Blood*.

First, Mitchell removed patients from their homes because 'it is well, for the mere alterative value of such change, to surround her with strangers and to put aside any nurse with whom she may have grown familiar.'<sup>50</sup> Mitchell would then order his patients to bed for up to eight weeks of rest. 'At first, and in some cases for four or five weeks,' Mitchell would not 'permit the patient to sit up, or to sew or write or read, or to use the hands in any active way except to clean the teeth.'<sup>51</sup> Constant rest and a rich diet often immediately revived exhausted patients, and usually resulted in rapid weight gain. 'Certain difficulties' soon arose, however, 'because... vessels, unaided by changes of posture and by motion, lose tone, and ... defects of nutrition occur.'<sup>52</sup> Mitchell used a combination of massage and electrical stimulation therapy as forms of passive exercise to prevent muscle atrophy.<sup>53</sup>

Although neurasthenia was originally defined with professional-class men as its primary victims, women quickly came to represent roughly half of all neurasthenic patients.<sup>54</sup> Today, due to a variety of factors including Mitchell's practice, personal narratives such as Charlotte Perkins Gilman's story 'The Yellow Wallpaper,' as well as iconography including the paintings of Thomas Eakins, and the confounding of the categories of neurasthenia and hysteria, Victorian women are more closely associated with neurasthenia than men.<sup>55</sup> Interestingly, the story of Margaret Cleaves, a female neurologist and 'neurasthene,' has not played a prominent role in the gendering of the history of neurasthenia.

### Women and Neurasthenia: Mitchell's Patients

<sup>46</sup> S. Weir Mitchell, 'The Evolution of the Rest Treatment,' *Journal of Nervous and Mental Diseases* 31, 1904, 368.

<sup>47</sup> Gosling, 109.

<sup>48</sup> Mitchell, 1904, 369.

<sup>49</sup> Mitchell, 1904, 370.

<sup>50</sup> S. Weir Mitchell, *Fat and Blood: An Essay on the Treatment of Certain Forms of Neurasthenia and Hysteria*, J.B. Lippincott & Co., Philadelphia, 1884, p. 50.

<sup>51</sup> *Ibid.*, p. 58.

<sup>52</sup> *Ibid.*, p. 68.

<sup>53</sup> Mitchell, 1904, p. 371.

<sup>54</sup> Gosling, p. 34.

<sup>55</sup> This study operates on the premise that neurasthenia was a disease category distinct from hysteria and other nervous diseases. Other scholars disagree, and examine nervous illness as a whole, or characterize hysteria as the original nervous illness, and other diseases as subcategories of hysteria. Due to space limitations, I cannot discuss this fascinating and valid debate. For an extraordinary study of women and the iconography of neurasthenia, see: Katherine Willimas, et al., eds/contributors. *Women on the Verge: The Culture of Neurasthenia in Nineteenth-century America*, Cantor Arts Center at Stanford University, Stanford, 2004.

In neurasthenia's founding texts, women appear as historical and allegorical figures, but not as patients.<sup>56</sup> The 'savage' woman of pre-modern times and pre-modern peoples, 'strong, well developed, and muscular,' has the 'capacity for enduring toil, as well as child-bearing' provided a striking contrast with the 'tender and beautiful women of the white races.'<sup>57</sup> In his preface to *American Nervousness*, Beard lists 'the education of women' as one of the five characteristics of modern civilization, which he names the 'chief and primary cause of this development and very rapid increase in nervousness.'<sup>58</sup> These modern women, however, were not neurasthenics themselves. Rather, they were social barometers with which Beard measured the advancement of society.

In actual American society, neurasthenic women accounted for roughly half of all case reports published in medical journals.<sup>59</sup> However, gynecologists, rather than neurologists, reported 20% of those cases.<sup>60</sup> This is not surprising, given the close relationship assumed to exist between a woman's reproductive organs and her nervous system.<sup>61</sup> As a result, neurologists and gynecologists practiced in fierce competition with one another. Neurologists argued that gynecologists were wrong in their insistence on the primacy of women's reproductive organs, and performed unnecessary surgeries on women, while gynecologists claimed that they were succeeding where the neurologists had failed, i.e. in finding the physical lesions causing nervous illness.<sup>62</sup>

However, many women sought treatment from neurologists. Because some nervousness was expected in women, their cases were marked 'cured' or 'improved' at a slightly higher rate than those of neurasthenic men.<sup>63</sup> Some women, however, were considered to be incurable. Mitchell was famous for taking on these cases.<sup>64</sup> Unlike other texts on the subject, *Fat and Blood* is written entirely with female pronouns. The rest cure and Mitchell's application of it reflected his patriarchal convictions and general distrust of women, and his seemingly contradictory respect for women's domestic work.<sup>65</sup> Despite his long and successful career, Mitchell is most widely remembered today for his unsuccessful encounter with Charlotte Perkins Gilman, who gave a fictionalized account of her experience in her short story, 'The Yellow Wallpaper.'

Gilman was born in 1860 to a socially upper-class, but economically destitute family.<sup>66</sup> After her father left when she was nine, Gilman observed the breakdown of Victorian gender roles in her family. Her father had abdicated his responsibility to provide for his family, and her mother was left without the means or opportunity to

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<sup>56</sup> *A Practical Treatise on Nervous Exhaustion, Neurasthenia*, First Edition: 1880, and *American Nervousness, It's Causes and Consequences*, First Edition: 1881 by George Miller Beard

<sup>57</sup> Beard, 1880, pp. 184-185.

<sup>58</sup> *Ibid.*, p. vi.

<sup>59</sup> Gosling, p. 34.

<sup>60</sup> *Ibid.*, p. 56.

<sup>61</sup> *Ibid.*, p. 22.

Modern constructions and disease categories such as 'PMS' and postpartum depression reveal that a woman's mental health continues to be closely associated with her reproductive biology.

<sup>62</sup> *Ibid.*, pp. 22-23.

<sup>63</sup> *Ibid.*, p. 63.

<sup>64</sup> Suzanne Poirier, 'The Weir Mitchell Rest Cure: doctor and patients.' *Women's Studies*, 1983, pp. 10, 20. Irwin Neff, an asylum superintendent in Michigan, also outlined a modified version of Mitchell's rest cure for those who could not afford the full treatment, or for men who had to work.

Gosling, p. 114.

<sup>65</sup> David G. Schuster, 'Personalizing Illness and Modernity: S. Weir Mitchell, Literary Women, and Neurasthenia, 1870-1914.' *Bulletin of the History of Medicine*, 2005. pp. 79, 702.

Poirier, p. 23.

<sup>66</sup> Gail Bederman, *Manliness and Civilization*, University of Chicago Press, Chicago, 1995, p. 124.

construct a 'domestic retreat' for her husband.<sup>67</sup> Gilman saw her mother's experience as evidence of the unjust limitations imposed on women. This upbringing, combined with the influence of her suffragist aunts, helped to develop in Gilman a sense of duty and strong 'desire to help humanity.'<sup>68</sup>

Gilman believed that 'it was normal and right' for a woman to marry, but 'the nature of the life before me forbade it, [and] I ought to forego the more intimate personal happiness for complete devotion to my work.'<sup>69</sup> However, at the age of 24, she married her first husband. After the birth of her child in 1885, she spiraled in a deep depression.<sup>70</sup> Gilman went to Philadelphia 'with the utmost confidence' to seek help from Mitchell, but problems arose almost immediately.<sup>71</sup>

Mitchell's rest cure relieved patients who suffered from physical exhaustion or anemic fatigue, but his methods often aggravated cases of mental distress.<sup>72</sup> Gilman herself wrote in her autobiography, 'what ails me is a weak mind in a strong body,' and she expressed concern that rest would not help her.<sup>73</sup> Nevertheless, she respected the famous doctor, and hoped to establish a working relationship with him, as is evidenced by the long letter she wrote to him detailing her family's history of nervous illness. She attempted to demonstrate that she had inherited neurasthenia, and looked to Mitchell to justify her desire to distance herself from her immediate family.<sup>74</sup> Instead, Mitchell rejected her attempt to engage him, and determined that her letter was another symptom of her nervous weakness and an act of selfish indulgence.<sup>75</sup> Mitchell already 'had a prejudice against the Beechers,' having treated two of Gilman's aunts, and Gilman's first impression deepened his distrust of her.<sup>76</sup> Despite this inauspicious beginning, Gilman remained dedicated to her treatment while in Philadelphia. After completing her treatment at his clinic, he gave her the now infamous advice, 'Live as domestic a life as possible. Have your child with you at all time. ... Have but two hours' intellectual life a day. And never touch pen, brush or pencil as long as you live.'<sup>77</sup>

Gilman claimed that she wrote 'The Yellow Wallpaper' to 'reach Dr. S. Weir Mitchell, and convince him of the error of his ways.'<sup>78</sup> She claimed that, in response to her account, Mitchell altered his treatment, although there is no evidence of this.<sup>79</sup> That this story was directed at and portrays Mitchell, however, is obvious. A woman

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<sup>67</sup> Ibid., p. 125.

<sup>68</sup> Bederman, p. 126

Charlotte Perkins Gilman, *The Living of Charlotte Perkins Gilman*, The University of Wisconsin Press, Madison, 1963, p. 70.

<sup>69</sup> Gilman, *Living*, p. 83.

<sup>70</sup> 'You did it yourself!... You were called to serve humanity, and you cannot serve yourself.' Ibid., p. 91.

Modern readers might identify Gilman's suffering with the modern category of postpartum depression. Endocrinology, the study of hormones, emerged in the first half of the twentieth century. Since that time, endocrinologists have asserted that hormones can have a strong influence over one's mental and emotional health. Women in particular are thought to be unduly influenced by changes in their hormone levels.

<sup>71</sup> Ibid., p. 95.

<sup>72</sup> Poirier, p. 22.

<sup>73</sup> Gilman, *Living*, p. 103.

Gilman's diaries detail an increasingly intense battle with anxiety and perfectionism, exacerbated by her family's poverty, her transient childhood, and an unhappy relationship with her mother, which intensified after the birth of Gilman's daughter.

<sup>74</sup> Denise D. Knight, 'All the Facts of the Case: Gilman's Lost Letter to Dr. S. Weir Mitchell,' *American Literary Realism*, 37(3), 2005, p. 264.

<sup>75</sup> Poirier, p. 26.

<sup>76</sup> Knight., p. 265.

<sup>77</sup> Mitchell, In: Gilman, *Living*, p. 96.

<sup>78</sup> Gilman, *Living*, p. 121.

<sup>79</sup> Poirier, p. 26.

suffering from neurasthenia narrates the story through her thoughts in the first person. Her physician-husband represents Mitchell. He insists that his wife is getting better, and the narrator feels powerless to oppose him, even though she knows that she is still very ill.<sup>80</sup> At first, he dismisses her concerns as frivolous worrying, but gradually becomes increasingly frustrated, if not angry with her persistent questioning. Mitchell himself wrote, 'wise women choose their doctors and trust them. The wisest ask the fewest questions.'<sup>81</sup> Eventually, the narrator is driven to madness by her treatment, which to her felt like entrapment. She escapes by descending into complete madness, just as Gilman did upon returning home.<sup>82</sup>

Gilman initially faced resistance from publishers, but today 'The Yellow Wallpaper' is her best-known work. It paints a damning portrait of Mitchell as an 'imperious, egotistical man who had little use for women who failed to adhere to traditional gender roles.'<sup>83</sup> Mitchell may have been all of those things, but this one-dimensional view of him shaped by Gilman's account alone fails to explain his immense popularity with women, and obscures the complex relationships-turned-friendships that Mitchell developed with many of his female patients. Gilman's experience was not an anomaly, and she was in good company among those who rejected his methods, which were far from foolproof. However, it is worth exploring some of Mitchell's success stories. In doing so, it is possible to contextualise his treatment of Gilman, which appears less evil, though still misguided.

Despite writing in his 1888 book *Doctor and Patient* that men and women had different intelligences that education could never change, Mitchell enjoyed the friendship and company of intelligent women, and displayed great respect for the work and opinions of his female correspondents.<sup>84</sup> One such woman was Amelia Gere Mason, who was overwhelmed by the duty of caring for her sick husband. Mason credited Mitchell with 'restoring value to her life.' Because they lived in different cities – Mason in Chicago, Mitchell in Philadelphia – they rarely met in person, but rather sustained their thirty-two-year-long relationship through correspondence starting in 1882. Eventually, the doctor-patient relationship gave way to a mutually respectful friendship.<sup>85</sup>

Mitchell relied heavily on his 'force of character... to secure the confidence and respect of his patients.'<sup>86</sup> While Gilman found him to be imperious, Mason liked his "impersonal' demeanor.' She claimed his detachment made him 'the perfect person with whom women could share their problems and secrets.'<sup>87</sup> Unlike other doctors, indeed, other men, Mitchell recognized and appreciated the demands domestic duties placed on women. Although he believed that women could best contribute to society as wives and mothers, he acknowledged that this work was taxing.<sup>88</sup> Mason compared Mitchell's office to a Confessional, and freely shared her thoughts and concerns. Unlike Gilman, however, and despite Mitchell's stated preference for deferential women, Mason actively questioned and challenged Mitchell's patriarchal assumptions and more 'autocratic' practices.<sup>89</sup>

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<sup>80</sup> 'He does not know how much I really suffer. He knows there is no *reason* to suffer, and that satisfies him.'

Charlotte Perkins Gilman, 'The Yellow Wallpaper', The Feminist Press, Old Westbury, 1973/1899), p. 14.

<sup>81</sup> In: Poirier, p. 26.

<sup>82</sup> Gilman, 'Wallpaper.' Summary.

<sup>83</sup> Knight, p. 265.

<sup>84</sup> Schuster, p. 702.

<sup>85</sup> Schuster, p. 705.

<sup>86</sup> Mitchell, *Fat and Blood*, p. 46.

<sup>87</sup> Schuster, p. 706.

<sup>88</sup> Poirier, p. 21.

<sup>89</sup> Schuster, p. 708.

In contrast with his advice to Gilman, Mitchell encouraged Mason to engage in intellectual and creative activities. He reserved his rest cure for only the most severe cases after every other measure had failed. This approach ensured that the patient stayed properly nourished, and, by placing them in a controlled environment, Mitchell could direct their thoughts and focus. For milder cases, like Mason, Mitchell encouraged his patients to occupy their minds to keep them from dwelling in vain introspection.<sup>90</sup> Mitchell regularly challenged Mason to think and write critically about literature and poetry, shared his own fiction with her and often posed philosophical questions in his letters to her.<sup>91</sup> With Mitchell's encouragement, Mason undertook a seven-year research and writing project, the product of which was her book, *The Women of the French Salons*.<sup>92</sup>

Mitchell also encouraged the work of Sarah Butler Wister, who was not only his patient, but also his cousin and the model for many of his fictional characters. Since childhood, they had relied on one another for emotional support. In adulthood, Mitchell provided Wister with medical advice, and Wister edited Mitchell's novels. A slew of sick and nervous family members drained Wister of her strength, and she soon became depressed, if not suicidal.<sup>93</sup> Mitchell encouraged her to paint every day. This activity forced Wister to abandon her work, and clear her mind. Both Mitchell and Wister appreciated the need for women to have personal time away from their domestic responsibilities.<sup>94</sup>

Reading, drawing, painting, and writing were all legitimate activities for women, so long as they were escapist in nature. Mitchell himself engaged in writing fiction to 'keep from dwelling upon [the] intolerable calamity' of his daughter's premature death.<sup>95</sup> Gilman's work, however, was the sort of morbid introspection that Mitchell believed exacerbated her depression.<sup>96</sup> Furthermore, although Mason challenged Mitchell's attitudes towards women in her letters, and admitted to disliking strict gender roles, she was not political. Her book, though an impressive accomplishment, was a history project detailing intellectual life in France. Like Mason and her private feminism, it was a commentary on society rather than an attempt to enact change. Gilman, however, thought it was her duty to change the world, and her intellectual work reflected that conviction.<sup>97</sup> Mitchell ordered Gilman to stop engaging in intellectual activity he believed was politically and biologically inappropriate, and attempted to refocus her energy and passion towards the domestic sphere. Whereas Wister and other patients were overwhelmed by their commitment to their families and needed solitude to regroup, Gilman already isolated herself. Mitchell observed that she did not need private time to regroup. Gilman's mind was cause of her problems, and Mitchell directed her to re-engage with her family. She had been looking for permission to leave her family, and he could never condone such flagrant upending of the social order.<sup>98</sup>

Although she claimed to trust Mitchell's medical advice, Gilman was never comfortable working with him. As she described it, she 'rigidly' followed his orders. Unlike Wister and Mason, Gilman did not actively engage in her treatment after Mitchell's initial rejection of her letter. She was too intimidated to challenge him like Mason, and did not have the personal connection with him that Wister had. Her

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<sup>90</sup> Ibid., p. 709.

<sup>91</sup> Ibid., p. 710.

<sup>92</sup> Ibid., p. 710.

<sup>93</sup> Ibid., p. 713.

<sup>94</sup> Ibid., p. 715.

<sup>95</sup> In: Schuster, p. 710.

<sup>96</sup> Schuster, p. 719.

<sup>97</sup> Bederman, pp. 128-129.

Also see: Gilman, *Living*. Esp. p. 91.

<sup>98</sup> Knight, p. 265.

treatment failed for many reasons, not the least of which being that she failed to transform her treatment into something personal from which she might benefit.<sup>99</sup> When viewed in the context of Mitchell's wider practice, his treatment of Gilman seems less intentionally cruel, though still ultimately wrong-headed.

Aside from a vague account of her experience in her autobiography and the essay 'Why I Wrote the Yellow Wallpaper,' Gilman never spoke of her experience with Mitchell again. However, she transformed his legacy. Today, Mitchell is remembered primarily as a cruel, egotistical misogynist. In his lifetime, however, he was one of the most popular and celebrated physicians in the United States.<sup>100</sup> At the peak of his practice, he was supposedly earning \$70,000 a year.<sup>101</sup>

During his lifetime, Mitchell's rest cure was famous for its remarkable success rate rather than for its failures. However, Gilman was far from Mitchell's only failure. The rest cure only worked within the narrow realm of physical debility and simple exhaustion.<sup>102</sup> Although Mitchell recognized that the mind and the body were more closely related than other nineteenth-century physicians would acknowledge, he still believed that emotions were subordinate to chemistry or pathology.<sup>103</sup> He was convinced that women who failed to recover remained sick because they refused to listen to his advice. They were malingerers, like some of the soldiers he encountered in the army. To discourage this behavior and encourage these women to return to society, Mitchell made convalescence unpleasant and infantilizing. Although he recognized that women's work was strenuous, Mitchell also did not trust women to be truthful, and expected them to take advantage of his sympathy.<sup>104</sup> He believed that women were divinely ordained and physically built to be mothers and wives.<sup>105</sup> It was acceptable for women to seek independent expression as long as they eventually returned to their domestic duties. Mitchell saw devotion to other goals, such as higher education and a career, not only as selfish and unnatural, but also dangerous to women's health, and frequently blamed his patients' suffering on such activities. Mitchell also was very conscious of cultural sex roles and the presumed natural superiority of men, and the success of his treatments rested on his ability to wield his authority freely. This religious devotion to, and scientific investment in the importance of social roles sometimes made him blind to cases of serious mental illness, and underlying organic disease.<sup>106</sup>

Even if they had not had such dramatically incompatible personalities, as discussed, S. Weir Mitchell probably could not have cured Charlotte Perkins Gilman. His 'cure' eventually drove her to total breakdown not because she actively rebelled against it, but because it was an inappropriate response to her illness.<sup>107</sup> Despite her protestations to the contrary, Gilman was a resilient and resourceful woman, and eventually recognized that Mitchell could not cure her. In order to rebuild her health, Gilman divorced her first husband, recommenced her intellectual life, and worked as a prolific author and popular speaker. When she died, it was by her own hand in the face of terminal breast cancer.

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<sup>99</sup> Schuster, p. 720. A modern understanding of hormones might also have helped her.

<sup>100</sup> Schuster, p. 703.

<sup>101</sup> Gosling, p. 37.

<sup>102</sup> Poirier, p. 22.

<sup>103</sup> *Ibid.*, pp. 17, 22. The modern concept of depression holds that emotions and brain/hormonal chemistry are inextricably linked.

<sup>104</sup> *Ibid.*, pp. 23-24.

<sup>105</sup> *Ibid.*, p. 22.

<sup>106</sup> *Ibid.*, p. 22.

<sup>107</sup> Although Freud had begun developing psychoanalysis and talk therapy in Europe at around this time, it would be several decades before these developments would reach and becoming popular in the United States. As mentioned above, endocrinology was also several decades away.

Mitchell also treated a young woman named Winifred Howells. The daughter of a friend of Mitchell's, Howells suffered a collapse in her mid-teens while away at school. Howells was a textbook self-inflicted female neurasthenic, according to Mitchell. She was a bright and enthusiastic student, and enjoyed composing poetry. Mitchell quickly blamed her 'unnatural' educational pursuits and self-indulgent hobby for her troubles. Howells dropped out of school, and spent the rest of her life sleeping and eating. Although she ate up to eight meals a day, she failed to thrive. Mitchell oversaw her care from a distance for ten years before actively taking over the case. When she continued to decline, Mitchell began force-feeding her. Shortly thereafter, Howells died. An autopsy revealed an organic cause for her illness.<sup>108</sup> Mitchell's handling of the Howells case illustrates how completely social convention could rule his medical perception.

Howells was not the only patient that Mitchell killed. Her story stands out, however, because of Mitchell's friendship and correspondence with her father, William Dean Howells. Although their friendship seems to have continued after her death, Wm. Howells questioned the validity of Mitchell's insistence that women abandon outside interests that he deemed inappropriate.<sup>109</sup> Howells also encouraged Gilman to publish 'The Yellow Wallpaper,' and included it in a volume he edited entitled *Masterpieces of American Fiction*.<sup>110</sup> These small, but pointed, actions strongly suggest that he did not hold Mitchell blameless for the death of his daughter.

### Women and Neurasthenia: Dr. Margaret Cleaves and *The Autobiography of a Neurasthene*

Like Charlotte Perkins Gilman, Dr. Margaret Cleaves experienced a childhood marked by poverty, loss, and a desire to have a better life than her mother. Margaret Abigail Cleaves was born in 1848 in Iowa. Her father was a physician by apprenticeship.<sup>111</sup> Of seven children, six were girls. The only son died in infancy of whooping cough. 'From that time on I was my father's 'boy' and we were close companions and comrades,' she wrote.<sup>112</sup> When she was 14, her father died, leaving the family in a precarious financial situation. Cleaves began teaching school the next year to raise money for her own education.<sup>113</sup> She graduated from the medical school at Iowa State University at the head of her class in 1873, and began her career at the State Hospital for the Insane in Mount Pleasant, Iowa, as second assistant physician, becoming only the second woman in the world serve as a physician in a public mental hospital. After working at Mount Pleasant for three years, she resigned to start a private practice. While in Iowa, she was granted admission to numerous medical societies, often becoming the first woman to join their ranks. In 1880, she was appointed physician-in-chief in the Female Department of the Pennsylvania State Lunatic Hospital in Harrisburg, Pennsylvania.<sup>114</sup>

Cleaves was a self-diagnosed neurasthenic, and insisted that she had shown symptoms in childhood.<sup>115</sup> After three years in Harrisburg, Cleaves resigned because of

<sup>108</sup> Poirier, p. 30.

<sup>109</sup> Ibid., p. 31.

<sup>110</sup> Ibid., p. 30.

<sup>111</sup> Margaret A. Cleaves, *The Autobiography of a Neurasthene*, Richard G. Bader/The Gorham Press, Boston, 1910, p. 24.

<sup>112</sup> Ibid., p. 29.

<sup>113</sup> Cleaves, 1910, p. 45.

<sup>114</sup> Frances E. Willard and Mary A. Livermore, eds *A Woman of the Century: Fourteen hundred-seventy biographical sketches accompanied by portraits of Leading American Women in All Walks of Life*, Charles Wells Moulton, New York, 1893, pp. 181-182.

<sup>115</sup> Cleaves, 1910, p. 33. Cleaves insists that her childhood fear of the dark was actually symptomatic of her nervous illness.

her illness. She travelled through Europe for two years, and eventually returned to Iowa to serve on the examining committee of the Medical Department of the Iowa State University. In 1890, she retired from her position in Des Moines, and moved to New York City to open an electro-therapeutic office.<sup>116</sup> In 1895, she became director of the New York Electro-Therapeutic Clinic and Laboratory, as discussed above.

In addition to her medical texts, Cleaves left behind a memoir, *The Autobiography of a Neurasthene: As Told By One of Them* (1910).<sup>117</sup> Rather than a chronological autobiography, *Autobiography of a Neurasthene* is the story of Cleaves' experience with neurasthenia. She primarily focuses on her own illness, but occasionally shares anecdotes from her practice. She does not include any dates in her story, nor does she share many details of her own life before adulthood beyond episodic windows related to her neurasthenia, or tragic events that invaded her thoughts.

Women doctors, especially high-ranking hospital administrators like Cleaves, were a rarity in the early twentieth century. Cleaves, however, did not consider her career to be a feminist statement. Just as she set herself apart from her sisters by becoming her father's 'boy,' so as a physician did she set herself apart from most women.<sup>118</sup> Her *Autobiography* opens with the statement, 'This is the biography of a physician. ... It does not matter whether it was really a man or a woman.'<sup>119</sup> She identified primarily as a neurasthenic, as is evidenced by the title and focus of her memoir, and then as a physician. She went so far as to say, 'I am absolutely aware that I live on a different plane from the average human being.'<sup>120</sup> Unlike Mitchell, Cleaves did not consider women's domestic duties to be work. She claimed that 'the complete exhaustion of supreme nerve centers' that befell her 'rarely befalls a woman,' because women rarely work in the professional classes.<sup>121</sup> She opposed the use of the rest cure, writing, 'the hardest cases I have had to take care of professionally are those who have acquired the rest cure habit,' claiming that that approach leaves patients unable to effectively manage their illness in a productive way. Cleaves justified her own 'self-indulgent' napping by saying that she was doing 'the hardest kind of work.'<sup>122</sup> In a particularly telling scene, after returning home from an extended vacation, Cleaves imagines her retirement, with 'desire tak[ing] the form of a simple furnished cottage... [where I can] busy myself with simply 'homey' duties... [and] play that I am a woman not a doctor.'<sup>123</sup> To Cleaves, being a 'woman' meant being a housewife.

Cleaves treated both male and female members of the New York City medical community in her private practice, and submitted herself to the care of a colleague to manage her neurasthenia.<sup>124</sup> Cleaves seems to have been afforded all of the respect due to her on account of her profession regardless of her sex. In addition to her own self-diagnosis, her doctor/colleague gave her a diagnosis of cerebral neurasthenia, the elite branch of neurasthenia belonging to the professional class, telling her, 'the trouble with you, doctor, is that you have sprained your brain.'<sup>125</sup> Occasionally, however, a colleague would remind Cleaves of her sex. At one meeting, when she 'had made a more strenuous and pitiful appeal than usual,' her physician 'teasingly whispered—

<sup>116</sup> Willard and Livermore, p. 182.

<sup>117</sup> See: Margaret Abigail Cleaves, *Light Energy*, Rebman Company, New York, 1904.

<sup>118</sup> Poirier, p. 28.

For other examples of women employing this technique to explain their successful careers, see: Christine Stansell, *The Feminist Promise: 1792 to the Present*, Modern Library, New York, 2010).

<sup>119</sup> Cleaves, 1910, p. 5.

<sup>120</sup> In: Poirier, p. 28.

<sup>121</sup> Cleaves, 1910, p. 5.

<sup>122</sup> *Ibid.*, pp. 148-150.

<sup>123</sup> *Ibid.*, p. 147.

<sup>124</sup> *Ibid.*, p. 69.

<sup>125</sup> *Ibid.*, p. 63.

"Hysteria." Cleaves' 'feeling of hurt and indignity was extreme, I felt I could never forgive him....'<sup>126</sup> Cleaves was deeply offended when her colleague, jokingly or not, suggested that she was hysterical. Unlike neurasthenia, hysteria had a long history and a great deal of stigma attached to it. Although men could be, and were diagnosed with hysteria, it was a feminized ailment that implied that the sufferer was unstable, and that her complaints were imaginary.<sup>127</sup> Unlike neurasthenia, which commanded the respect of, and afflicted most of, the medical community, hysteria was a disease of the lowly and unsophisticated. In this instance, Cleaves sounds strikingly like Gilman. In her letter to Mitchell, written before she arrived at his clinic, she wrote, 'I beg of you not to laugh at me as every one else does.'<sup>128</sup> Cleaves went to see her physician after experiencing an increase in the severity of her physical symptoms, some of which she feared were not traditionally associated with neurasthenia. She worried that this physician did not appreciate the extent of her suffering and, by jokingly suggesting a diagnosis of hysteria, he confirmed her suspicions.<sup>129</sup>

Cleaves firmly believed that 'True neurasthenes are born initially, not made. The conditions of life may favor the development of the condition, but there is inherent at birth a fundamental nutritive lack of the nerve centres which predisposes under favorable environment to its development.'<sup>130</sup> Given her own experience with neurasthenia, Cleaves never doubted that neurasthenia was a fully realized disease, and she acknowledged the reality and power of its mental symptoms, writing: 'Mental anguish is harder to endure than physical pain. I know, for I have suffered both.'<sup>131</sup> She remembered two former patients, whom she describes as her ideal neurasthenes:

There are two charming young women, one a few years younger, the other just over the thirtieth milestone, both potential neurasthenes and both with the condition actually in evidence much of the time, because life's obligations have to be met out of a limited nerve reserve. They are not only capable and intelligent with well trained [*sic*] intellects, but in common with the rest of us psychical as well, not in any untoward way, but more of the soul than the material world. So keen and brilliant are they that one does not grow weary in their company and so appreciative of all good things that come their way as to give the keenest pleasure to the one that pleasures them.<sup>132</sup>

These women were what Cleaves would call 'essential neurasthenes.' In contrast with the essential neurasthenes were 'symptomatic neurasthenes,' who 'cloak themselves in the panoply of the neurasthene, bringing the true sufferer thereby into disrepute.'<sup>133</sup> These patients exhibit symptoms associated with neurasthenia and claim to suffer from neurasthenia, but, in Cleaves' opinion their diagnoses are not legitimate because they are not the 'type' that suffers from neurasthenia. Cleaves claims that most women are 'symptomatic' because they are 'toxic instead of exhausted.'<sup>134</sup> Cleaves describes 'a symptomatic neurasthene who has been under my care for the past seven or eight years:

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<sup>126</sup> Ibid., p. 79.

<sup>127</sup> Gosling, p. 9.

<sup>128</sup> Knight, p. 268.

<sup>129</sup> Cleaves, 1910, p. 79.

<sup>130</sup> Ibid., p. 18.

<sup>131</sup> Ibid., p. 101.

<sup>132</sup> Ibid., p. 53.

<sup>133</sup> Ibid., p. 18.

<sup>134</sup> Ibid., p. 64.

[The patient] was told many years since by a practitioner that she had an arthritis, that she never would be well and that she could eat as she pleased, it would make no difference. She has set herself resolutely to the carrying out of his prognosis and following his advice in the matter of eating—she weighs two hundred and sixty-five pounds—is never well. The term *arthritis* is rolled under her tongue as a delicious morsel. She has absolutely nothing of the sort, but unless physiological stimuli are pretty constantly used to keep up good tissue change, she gets by reason of her toxin-laden blood sore nerves and muscles.<sup>135</sup>

Cleaves even groups her late older sister with ‘the vast army of those evidencing a symptomatic neurasthenia. ... She would never have been an essential neurasthene, for her calibre was not that of immolation, nor had she the mind that found its highest interest in exacting studies.’<sup>136</sup>

Cleaves’ discussion of essential versus symptomatic neurasthenes is strikingly similar to Rockwell’s condemnation of lithemic neurasthenia discussed above. Unlike Rockwell, however, Cleaves insisted that she personally has suffered because of the duplicity of symptomatic neurasthenes. After a disastrous vacation in Europe, during which she nearly suffered a complete breakdown, Cleaves asked her doctor why he had allowed her to go. He answered simply that he had not realized how sick she was. Cleaves blames symptomatic neurasthenes for this disconnect between her and her doctor:

He would have realized more fully, and I would have had to suffer less, had it not been for the symptomatic neurasthene who dominates the field by reason of their greater frequency, their persistent pose and often hysterical conditions. The case of an utterly down and out, hard-working physician, whose physician and friends have united in saying ‘she is all brain and no body’ was very different.<sup>137</sup>

Cleaves again defines herself as a physician and essential neurasthene, setting herself apart from the disreputable crowd of usurpers. She laments that her doctor, although respectful of her as a colleague, does not seem to recognize the severity of her suffering and legitimacy of her identity.

Cleaves published her memoir in 1910, the year diagnoses of neurasthenia peaked.<sup>138</sup> ‘An eminent neurologist has written of the passing of neurasthenia,’ she noted, ‘Neurasthenia is not passing. It is the age of neurasthenia.’ On the eve of the First World War, however, the medical and social utility of neurasthenia had begun to be drawn into question. What can be recognized as modern psychiatry, which grew out of nineteenth-century neurology in the United States and France, had begun to displace the disease category of neurasthenia with its own constructions such as depression and bipolar disorder. Neurasthenia became an anachronism in a rapidly changing medical discourse.

## Conclusion

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<sup>135</sup> Ibid., p. 8.

<sup>136</sup> Ibid., p. 26.

<sup>137</sup> Ibid., p. 123.

<sup>138</sup> Tom Lutz, ‘Varieties of Medical Experience: Doctors and Patients, Psyche and Soma in America.’ In: Gijswijt-Hofstra and Porter, p. 51.

In the first decades of the twentieth century, some doctors, like Margaret Cleaves, insisted that neurasthenia was stronger than ever. Others, however, sensed that it was the beginning of the end for this centerpiece of nineteenth-century medicine. In 'The Partial Passing of Neurasthenia' (1904), Charles Dana, a famous New York-based neurologist, wrote: 'There has been, in fact, a kind of intellectual renaissance in psychiatry which has aroused deeply the interest and respect of neurologists.'<sup>139</sup> Dana predicted that over the next few years neurasthenics would be re-diagnosed using new disease categories.<sup>140</sup> Neurasthenia was no longer a mark of status, but rather that of an old system of medicine. Young psychiatrists openly maligned the disease, calling it 'a sort of blanket term to cover our ignorance of some functional nervous disorder which we find difficult to diagnose without careful and painstaking examination.'<sup>141</sup> Others recognized neurasthenia's future utility. Dr. Peter Bassoe wrote in 1928, 'The term neurasthenia is a mile stone in the history of medicine, which at first marked progress but now impedes it.' As a cornerstone of pre-World War I American medicine, neurasthenia is vital to understanding the history of medicine and culture at that time.

The term neurasthenia remained in American medical dictionaries until the mid-1980s, when it was finally removed because of lack of use.<sup>142</sup> Many modern disease categories, however, are just as socially constructed as and strikingly similar to neurasthenia. 'Stress' is one such construction.<sup>143</sup> Like Beard's disease, stress has no pathological identity. Its symptoms range from insomnia to cold extremities to hypertension, and treatments range from chemical antidepressants to yoga. Prior to the en masse entrance of women into the workforce in the second half of the twentieth century, and the increased recognition of women's work in the home as labor, stress was largely a male prerogative, much like neurasthenia as defined by Beard and its early adherents. Most importantly, stress is a sign of status. The stressed lawyer of 2012 is an intelligent, ambitious man or woman, who shoulders a great deal of responsibility. In 1890, he would have been a 'cerebral,' 'essential' neurasthenic.

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<sup>139</sup> Charles Dana, 'The Partial Passing of Neurasthenia', 1904. In: Gosling, p. 165.

'There have come of late years much clearer ideas of the nature and relationships of the insanities.... The analysis of symptoms has been keener and clinical study has been pursued with scientific methods.'

<sup>140</sup> Gosling, 165. Or their ailments would turn out to be the result of underlying organic conditions so as to prevent another Winifred Howells. For an account of the re-evaluation of soldiers diagnosed with neurasthenia during World War I, see: M.D. Clayton, 'When Is the Diagnosis of Neurasthenia Justified?', *U.S. Veterans' Bureau Medical Bulletin*, 1925, vol. 2.

<sup>141</sup> W.C. Ashworth, 'Neurasthenia,' *Virginia Medical Monthly*, 1921, pp. 48, 247.

<sup>142</sup> Lutz, p. 67. Neurasthenia continues to be diagnosed in China and Japan, however, where it was introduced in 1900 and 1920, respectively, as a "euphemistic diagnosis" because it still lacks the stigma of more serious mental diseases, such as schizophrenia.

<sup>143</sup> Gosling, p.173.